Legislative Audit Division

State of Montana

Report to the Legislature

March 2000

Performance Audit

Inmate Medical Services

Department of Corrections

This report contains recommendations for improvements to the management of medical services provided to inmates under the care and custody of the Department of Corrections. Our recommendations provide a framework to make the department's administration of inmate health care services more efficient and effective from both an operational and cost standpoint.

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March 2000

The Legislative Audit Committee
of the Montana State Legislature:

We conducted a performance audit of the management of medical services provided to inmates under the care and custody of the Department of Corrections. This report contains recommendations for improvements to the department's management of inmate medical services.

We wish to express our appreciation to the management and staff of the Department of Corrections for their assistance during the audit.

Respectfully submitted,

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Legislative Audit Division

Performance Audit

Inmate Medical Services

Department of Corrections

Members of the audit staff involved in this audit were Lisa Blanford, Kris Wilkinson, and Mike Wingard.

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Introduction

The Legislative Audit Committee requested a performance audit of inmate medical services administered by the Department of Corrections (DOC). The department is responsible for providing health care to adult and juvenile offenders incarcerated in department facilities and programs. Health care includes medical, dental, vision, and mental health services. The department is also responsible for ensuring Montana inmates housed in private prisons and other contracted beds receive adequate health care services. Our audit concentrated on the department's role in administering inmate health care services.

Cost of Inmate Health Care in Montana

As the prison system has grown, the cost of providing health care to inmates has increased and will continue to increase. In fiscal year 1998-99, the department spent at least $ 8.2 million for inmate health services. This included expenditures for providing medical, dental, vision, and mental health care to adult and juvenile offenders incarcerated in both DOC facilities and in contracted bed facilities.

In the past five years there have been rapid and dramatic changes for the Montana Department of Corrections. Foremost is the state's need for more inmate bed space. In response to this growth, the department turned to alternative means of housing inmates, including county jails, county-operated regional prisons, and privately operated prisons. Montana's adult correctional system evolved from three in-state secure facilities, all operated by the department, to a system of Montana inmates spread among nine secure facilities located both in-state and out-of-state, and operated by several entities. Management of the correctional system is now shared by state and county officials and privately operated facilities. This system expansion has made it more complex to manage and control health care expenditures. There are now more facilities providing medical services to inmates and thus more facilities to oversee. Also, the decentralization means systems to provide health care must be duplicated at each institution and thus opportunity for realizing efficiencies gained through economies of scale is limited. In addition to an increasing number of inmates and a decentralized prison system, the 1994 and 1997 lawsuits filed over health care

services at Montana State Prison (MSP) were key factors impacting medical expenditures.

In reviewing the department's expenditures for inmate health care, we examined department expenditures for overall cost trends, compared Montana's correctional health care costs to other western states, and contrasted inmate health care expenditures to the rate of medical inflation for this area of the country.

In comparing the experiences of Montana to other states, we found 13 states report either constant or decreased medical costs. States which experienced rising health care costs report an average increase in total correctional health care spending of 5.8 percent. This compares to an increase in total health care costs of 11.1 percent in Montana. Rapidly increasing health care costs faced by the Montana Department of Corrections suggest the need for expanded monitoring and oversight of correctional health care by the DOC. Increased monitoring and oversight may enable the department to better control costs while ensuring an adequate system of health care delivery. If health care expenditures continue to grow as they have been, the department will spend at least $10 million providing medical care to the current population of inmates in fiscal year 2001. This figure assumes no growth in the inmate population. Add an increasing population to this scenario and costs of health care could rise even further.

Improving Department Operations

Less than five years ago, the DOC operated all of the secure care facilities where adult and juvenile offenders were housed. By the end of the fiscal year 2000, the DOC is projected to have 2,200 inmates in at least nine different facilities, not including prerelease centers. Some of the facilities are state-operated, others are contracted. All of the DOC inmates are the responsibility of the state of Montana and all must receive and have access to health care services. The complexity and size of the inmate health care system has more than doubled as the result of inmate population growth and the necessary changes made to administer this population.

Our audit report states the DOC has focused the majority of its attention and resources on assuring public safety via expanding the number of available prison beds and increasing personnel responsible for the security and supervision of those inmates. As a result of the department's focus, there has been less attention given to other department responsibilities, such as the provision of health care which meets existing case law and judicial standards.

While the DOC has begun to address issues associated with the administration of inmate health care, the audit report shows there should be improvements made in that administration. Since medical delivery systems are for the most part set up at each of the nine adult and juvenile correctional facilities and the department has gained compliance with a portion of the court-ordered settlements governing health services at Montana State Prison, department management should now emphasize system wide oversight of the health care system.

Our audit report recommendations provide a framework to make the DOC's administration of inmate health care services more efficient and effective from both an operational and cost standpoint. In order to achieve this the department should:

1. Expand its long-range planning process to include specific goals and measurable objectives for the entire correctional health care system.

2. Develop, compile, and analyze comprehensive management information to allow for review of health care costs and utilization patterns statewide.

3. Continue to expand its managed care strategies by obtaining discounted rates from health care providers currently reimbursed on the full "usual and customary" fee schedules and shifting towards use of Medicaid- or Medicare-type fee reimbursement schedules as a basis for beginning contract negotiations with providers. Other positive gains could be made by changing practices and priorities based on reviews of the appropriateness of medical treatment and prescribing practices; by enforcing department policy regarding prior

authorization of off-site health care services; and by closely monitoring use of off-site and ancillary services.

4. Strengthen and expand procedures for review of medical billing by designating responsibility and adopting specific procedures for performing billing reviews. Medical billing management could also be improved by ensuring updated eligibility information is provided to claims administrators in a timely manner, and adopting a standardized medical preauthorization form and ensuring staff consistently complete all required information.

5. Implement a system wide quality improvement program which includes a formal schedule of facility visits and establishes procedures to ensure problems identified during quality improvement reviews are resolved in a timely manner.

6. Develop a contract administration and monitoring process: that clarifies responsibilities; thoroughly inventories health service contracts; ensures timely signing of contracts; verifies proper provider reimbursement; and, effectively monitors contract compliance.

7. Reexamine each facility's health care services organizational structure to clarify the reporting structure and clearly define the roles and responsibilities of managerial staff.

8. Develop and communicate procedures to ensure proper transfer of medical information during intra-system transfers, designate a responsible party for record transfer at each facility, and adopt a standardized intra-system medical transfer form or treatment plan.

Chapter I - Introduction

Introduction

The Legislative Audit Committee requested a performance audit of inmate medical services provided by the Department of Corrections (DOC). The department is responsible for providing health care to adult and juvenile offenders incarcerated in department facilities and programs. Health care includes medical, dental, vision, and mental health services. The department is also responsible for ensuring Montana inmates housed in private prisons and other contracted beds receive adequate health care services. Health care service programs are administered by the Professional Services Division of DOC located in the department's central office in Helena. Our audit concentrated on the department's role in administering inmate health care services.

Throughout the audit report, we use the terms medical services and health care services interchangeably.

Audit Objectives and Scope

Our general audit objective was to determine efficiency and effectiveness of the department's process for managing the delivery of inmate health care services. The audit focused on the provision of health care to adult inmates. Information relating to juvenile health care was gathered for informational purposes. Specific objectives included:

1. Identify the legal issues and correctional health care standards and guidelines which dictate the provision of inmate health care.

2. Examine how health care services are provided to inmates under the custody of the department.

3. Identify and assess costs and service utilization patterns associated with providing inmate health care.

4. Assess reasonableness of department actions to: ensure compliance with legal issues, correctional standards, and department policy; provide access to care; ensure timely and quality care; and contain and manage health care costs.

5. Examine department short-term and long-term strategies used to manage inmate health care.

6. Identify issues which impact the provision of health care and cost of services.

7. Develop inmate profile information on the overall physical health of the inmate population.

The scope of our audit focused primarily on central office oversight of health services provided to inmates incarcerated in state facilities, private facilities, and the regional prisons. Our audit work covered department operations up to July 1999.

Audit Methodology

To gain an understanding of how the Department of Corrections administers inmate medical services, we interviewed management and staff at the central office and at the institutions and reviewed legislative committee minutes, state laws, regulations, policies and procedures, and agency files. In addition, we reviewed budget and planning documents, publications on inmate health care, reports from other states and federal agencies, and other literature on prison operations.

We visited the department's medical infirmary and clinics at Montana State Prison in Deer Lodge and the Montana Women's Prison in Billings. We also visited two of the three regional prisons in the state -- Cascade Regional Prison and the Dawson Regional Prison. We evaluated the department's procedures for establishing and managing inmate health care activities. We analyzed staffing and expenditures, assessed the adequacy of management controls, and evaluated availability of program and financial data. In addition, we reviewed applicable accreditation standards developed by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC).

We reviewed mission and program statements, medical directives, program policy, and institutional procedures. We also examined department organization charts, staffing rosters, position descriptions, and staff reporting relationships. We assessed processes for communicating management's expectations to medical personnel.

We compiled and analyzed financial data relating to expenditures for inmate health care for fiscal years 1996 through 1999. We gathered and examined this data for all facilities housing adult and juvenile offenders, including secure and nonsecure facilities and state, county, and privately operated facilities. In addition, we reviewed nationwide health care expenditure information to benchmark against Montana's prison system. This included an examination and comparison of correctional health care, private health care, and other governmental health care programs.

We examined documents and reports related to two federal district court lawsuits challenging Montana's inmate health services program: the 1994 *Langford, et al. v. Racicot, et al.* lawsuit and the 1996 *United States of America v. State of Montana* lawsuit. We examined the Stipulated Settlement Agreements for both lawsuits, various court orders, progress reports filed with the court during five years of monitoring, findings of the court-appointed monitors, and DOC's written responses. We also interviewed court-appointed monitors and representatives of the American Civil Liberties Union (ACLU). We attended post-review meetings between the court monitors and DOC management.

We reviewed the department's contracts with private health service providers to determine scope of the contracts, what services are provided, and associated costs. We interviewed department staff to determine how health service contracts are administered and we examined controls used by the department to monitor and assess contract compliance.

Our audit work was conducted in accordance with government auditing standards for performance audits.

Criteria Used to Measure DOC Performance

We used the National Commission on Correctional Health Care (NCCHC) guidelines and standards as audit criteria to determine how health care services should be provided. The NCCHC is a nationally recognized organization which has developed minimum requirements for health care services in prisons, jails, and juvenile facilities. It has developed both standards and guidelines for use in operating correctional health care systems. The standards were established in conjunction with leading organizations in the health, legal, and correctional professions. They cover a wide variety of topics including: inmate care and treatment; facility governance and administration; health care services support, personnel, and training; managing a safe and healthy environment; special inmates needs and services; health promotion and disease prevention; health records; and medical-legal issues.

NCCHC also offers an accreditation program. Correctional facilities which meet NCCHC's standards for correctional heath care attain accreditation. NCCHC's sole purpose is "to improve heath care in correctional institutions." DOC management indicates one of their goals is to attain NCCHC accreditation at MSP. In addition, Montana's contract with the private prison located near Shelby, Montana, also requires the contractor to obtain NCCHC accreditation for its health care operations. Accreditation is beneficial because it certifies the facility meets professionally recognized standards. Experiences of other states further suggest accreditation reduces the threat of federal intervention in prison operations which can occur due to lawsuits.

Data Limitations

Government auditing standards require disclosure of any constraints imposed on the audit because of data limitations or scope constraints. During the audit, we attempted to gather data regarding inmate use of health services and associated costs. The department does not compile comprehensive program data related to inmate use of health services at various institutions. Although utilization information is available for off-site medical services, such data is not routinely compiled for on-site medical services or on-site/off-site contracted services. In addition, only limited health care cost information was available.

Although we were able to review individual Statewide Budgeting and Accounting System (SBAS) entries for a four-year period to compile health care expenditures. The lack of comprehensive health care utilization data limited our efforts to review usage patterns looking for indicators of excessive or costly use of services. It also limited our ability to identify underutilized services which could be an indicator of an inadequate level of health care. This limited our assessment of inmate use and associated costs of health services. This issue is discussed in detail in Chapter IV.

An additional audit objective was to develop inmate profile information on the overall physical health of the inmate population. The department does not routinely compile comprehensive information regarding general inmate health characteristics, such as communicable diseases, chronic health conditions, medical diets, dental conditions, and mental illness. While such information is available in each inmate's health file, the department has not routinely compiled health information for the population as a whole. We were therefore limited in our ability to provide such data in this report.

Management Memorandums

During the course of the audit, we sent management memorandums on several issues. The issues included:

- Confidentiality of inmate health records;
- Processing of health-related inmate grievances;
- Medical classification of inmates; and
- Recording of health care expenditure transactions.

Chapter II - Overview of Montana's Correctional Health Care System

Introduction

This chapter presents an overview of Montana's correctional health care system, including an explanation of how health care services are provided. It contains a discussion of legal issues which impact correctional health care and provides information on managing health care costs in a correctional setting.

Providing Health Care

Once a person is remanded to the care and custody of the Department of Corrections, the department becomes responsible for the care of that inmate. This includes providing basic housing and food service, offering chemical dependency and other behavior modification treatment programs, operating inmate work programs, and providing inmate health care services. A wide range of health care services are required including medical, dental, mental health, vision, and preventative or wellness programs. The extent of these responsibilities has been established via federal and state statute as well as through case law.

DOC's Professional Services Division, Health Services Management Bureau, was responsible for providing health services to an average daily population (ADP) of 1,487 adult and juvenile offenders incarcerated in state-operated correctional facilities during fiscal year 1999. Department staff were also responsible for monitoring health services provided to an ADP of 707 Department of Corrections' inmates housed in county, regional, and private correctional facilities during that same time period. Because the average period of incarceration is about two years, the majority of the prison population turns over every other year. These newly admitted inmates increase the health services workload. It is the policy of the department "to provide those health care services that preserve and maintain the health status of offenders during incarceration." In fiscal year 1999, the department spent at least $8.2 million on both on-site and off-site inmate medical services and had approximately 50 FTE plus contracted and private providers dedicated to providing these services.

Reception Services

Currently, each male and female inmate is screened to determine health status upon commitment to a correctional facility. Screening includes a complete physical, including any needed laboratory tests and diagnostic tests. Inmates receive a basic dental examination. Additionally, inmates receive a mental health evaluation, which includes testing and an interview by mental health staff. As a result of these evaluations, health services staff assign inmates a medical classification status that indicates the inmate's physical and mental capabilities. This information is used to facilitate a number of things, including future inmate health care, facility placement, and work assignments.

On-Site Health Care

Ongoing health care is provided on site at each correctional facility through department staff or contracted providers. On-site health care staff provide the primary care services to inmates. Each facility has a walk-in clinic. Each clinic typically supports a broad range of services, including sick call, emergency medical treatment, dental services, and optometry services. Physician Assistants and Nurse Practitioners are the primary care providers at most facilities. Nursing staff also provide health care to inmates and distribute inmate medications. Contract physicians are on call and may also have regularly scheduled office hours at facilities. Health care staff are generally available or on call 24 hours per day. In addition to the walk-in clinic, Montana State Prison also has an infirmary where physician and skilled nursing care is provided for inmates with more serious illnesses or diseases or for pre- or post-hospital care. The level and type of health care provided varies at each facility as do the methods used to provide services. For example, health care for MSP inmates uses a combination of department and contracted providers while Montana Women's Prison (MWP) relies entirely on contracted heath care services.

Off-Site Health Care

Inmates who require consultations with medical specialists or health care not readily available within the correctional facilities are transported off site to community physicians, clinics, or hospitals for treatment. Medical staff refer inmates to external clinics for many types of services, such as obstetrical, orthopedic, podiatry, surgical, dermatology, and oncology treatments. In addition, inmates housed in some facilities are transported outside the facility to receive dental and vision services. Of the approximately $8.2 million in expenditures, the department estimates it spent over $2.5 million for off-site medical services in fiscal year 1999.

Health Care System Oversight

Management oversight of the adult and juvenile correctional health care system is the responsibility of the Health Services Management Bureau of the Professional Services Division. This bureau is part of the central operations in Helena. Staff consists of the department's medical director, a health services manager who is a registered nurse, a managed care registered nurse, and an administrative assistant. The Health Services Management Bureau's responsibilities include:

- Develop and revise health policies, procedures, and protocols and managed care policies and monitor implementation efforts.
- Review and approve each facility's health care policies, procedures, and protocols.
- Enforce the drug formulary (listing of approved drugs).
- Ensure individual medical, dental, and mental health assessments are based on department policies and protocols.
- Provide policy guidance and oversight to health care personnel providing services to the offenders committed to the department.
- Monitor the level and quality of health services at each facility and program to ensure compliance with all applicable standards.

- Oversee the department's health-related, continuous quality improvement program.
- Provide professional direction and leadership.
- Guide the department's compliance with legal standards.

Staff from the Health Services Management Bureau travel to correctional facilities as part of their oversight responsibilities. In addition to oversight, the medical/mental health director also provides occasional primary-level health care to inmates housed in state-operated facilities and professional consultation with other medical providers. Final medical judgments rest with the department's medical/mental health director.

Inmates Right to Health Care

Lawsuits have been a driving force in the provision of correctional health care, both nationwide and in Montana. The delivery of correctional health care has been significantly impacted by over 20 years of litigation stemming from the filing of class action lawsuits by inmates. Since the 1970s, federal courts have mandated that prison officials have a duty to provide medical treatment to inmates. The courts have determined the intentional denial of necessary medical treatment to an inmate is "cruel and unusual punishment," violating the Eighth Amendment to the Constitution of the United States. The United States Supreme Court ruled in *Estelle v. Gamble,* 429 U.S. 97(1976), that inmates have a constitutional right to health care. This and other federal court decisions have held that inmates have the following three general rights related to medical care:

- **Right of access to care**: Access to care must be provided for any medical, dental, or psychological condition if the denial of care might result in pain, suffering, or a worsening of the condition.
- **Right to care that is ordered**: Care or a plan of treatment prescribed for an inmate must be provided. This can include prescribed medication, rest, and release from work assignments.

- **Right to a professional medical judgment**: Medical staff must be qualified and able to treat the inmate's medical problems or refer the inmate to outside medical sources who can.

Health care is a primary issue in most class action lawsuits alleging unconstitutional conditions of confinement.

Denying Health Care Results in Litigation

The failure of correctional officials to honor the right to medical care often results in lengthy litigation, awarding of damages and attorneys' fees, and issuance of injunctions regarding delivery of health care services. The U.S. Department of Justice reports that as of January 1994, 28 states were under federal court order or consent decrees with challenges regarding the provision of health care. This results in all or portions of a facility's health care system being placed under the scrutiny and monitoring of a federal court.

Montana DOC Health Care Under Court Scrutiny

Two separate federal district court lawsuits successfully challenged conditions of confinement including medical, mental health, and dental care provided to inmates housed at Montana State Prison: *Langford, et al. v. Racicot, et al.* and *United States of America v. State of Montana*. As a result of these lawsuits, Montana State Prison has been operating under court jurisdiction since 1994 relative to health care. The two court-ordered settlement agreements contain 29 issues related to basic health care which are to be resolved by the department. For example, when an inmate is sick their health assessment must be conducted by medical staff, not security staff. Another issue requires that each incoming inmate receive an initial intake health screening within 24 hours of admission to the prison. These screenings should include a medical history and physical and vital signs. Intake health screenings are important for identifying communicable diseases. There is also a provision which requires that chronically ill inmates, such as diabetics or asthmatics, be seen by a medical provider on a regular basis. The settlement agreements contain other issues that relate to the provision of medical, mental health, dental, and vision services.

Progress towards compliance with the terms of the agreements is monitored by court-appointed monitors who are national experts in the field of correctional medicine. This monitoring team (at the expense of the state) has regularly visited MSP since 1995 to determine compliance with the settlement agreements. The department must achieve a standard of "substantial compliance" for two successive reviews in order for the department to petition the court to dismiss each issue from the settlement agreements. Although portions of the settlement agreements have been dismissed, the department continues to work towards complying with several major provisions. Unresolved issues primarily include three areas:

1. Nursing protocols: Nursing staff are not consistently following standing orders or protocols for treatment of inmates. This has resulted in deficiencies handling inmate sick call requests and providing urgent care services. Other issues include documenting inmate health-related information and gaps in supervision of both sick call and urgent care nursing staff.

2. Sick call for inmates: There are procedural deficiencies with the sick call process including staff not collecting requests daily, staff not consistently logging that requests were collected, and inadequate documentation on sick call logs. Triage-related concerns include improper nursing assessment of inmate sick call requests and incomplete documentation of nursing assessments in inmate files. In addition, concerns were identified related to inadequate documentation of referrals to advanced-level practitioners and referral outcomes.

3. Patient referrals for medical services: Although the system of referring inmates to midlevel practitioners or physicians has worked "fairly well," an unacceptable number of appointment cancellations exists. Difficulties transporting inmates to off-site health care appointments has resulted in a cancellation rate of 30 to 50 percent per month. Department management indicated that difficulties communicating transportation needs to the Transportation Unit caused this problem.

Department and facility staff have been dealing with these lawsuits since 1994 and the health care issues have not been entirely resolved. Department officials acknowledge a substantial amount of "man hours" have been expended related to the lawsuits and in gaining compliance with the settlement agreements. Department officials estimate over $4.5 million of claims and $1.3 million of attorney fees resulted from litigation regarding conditions of confinement at MSP, a portion of which relates to the delivery of health care to inmates. In addition, the 1997 Legislature appropriated nearly $1.5 million and 19.5 FTE to allow the department to implement legally adequate standards of care for health-related services at MSP. A portion of these resources was for medical services and a portion for mental health services.

Health Care Can Impact Security and Cost of Services

According to NCCHC, the litigious environment associated with correctional health care has resulted in additional impacts. Poor health services can impact the prison environment by agitating inmates which can compromise prison security. If inmates do not have timely access to health care, or are otherwise dissatisfied with the level of health care provided, they can become disruptive. Health care services are one of the most commonly grieved areas. Facility wardens agree health care can impact prison security.

NCCHC also states, "in systems where the quest for quality is driven by litigation concerns, one of the almost inevitable consequences is an increase in the cost of care, owing not just to providing a higher level of service, but also to providing care that is not needed." Practicing defensive medicine is not unique to corrections. Fear of malpractice lawsuits leads many clinicians to order expensive diagnostic tests and procedures in order to rule out even the remote possibility of rare diseases and conditions. Such practices, coupled with the availability of advanced technology, contribute to increased costs of heath care.

Legal Issue Summary

A government's obligation to provide medical, dental, and mental health care to inmates is well established. Institutions must develop an organized system of care that guarantees each inmate's right of access to care when needed, guarantees that medically ordered care is in fact provided, and ensures professional medical judgment respecting the need for care is afforded.

Balancing Inmate Access to Care While Controlling Costs

The fact that inmates are legally entitled to health care does not mean the state is obligated to provide every type of medical service imaginable. The state's obligation is threefold. First, prisoners must be able to make their medical problems known. Second, the medical staff must be competent to examine inmates and to diagnose their illnesses. Third, staff must treat the inmate's medical problems or refer the inmates to outside medical sources who can.

In providing health care, administrators must typically provide care while controlling costs. According to the U.S. Department of Justice, it is permissible and reasonable for health care administrators and providers to define appropriate and necessary medical care and inappropriate and unnecessary medical care. Limits as to what care will be provided can be set in order to allocate medical resources or limit access to unnecessary health care services. Not every medical procedure which is technologically possible or which is commonly performed in free society is obligatory for prisoners. For example, prisoners are not entitled to cosmetic surgery at public expense.

It is the department's policy to provide health care services that preserve and maintain the health status of offenders during incarceration. The following chart illustrates the policy established by the Montana Department of Corrections for determining medical care, allocating medical resources, and controlling costs. The department has a Medical Review Panel which meets and applies these standards.

Table 1
Department of Corrections Levels of Therapeutic Care

Level 1:	**Medically Mandatory**: care that is provided to all prisoners. Examples: arterial or venous lacerations, myocardial infarction, major head injury.
Level 2:	**Presently Medically Necessary**: may be provided to prisoners subject to periodic utilization review and authorization. Examples: treatment of chronic conditions such as insulin dependent diabetes, supportive care such as pain management, care of infectious diseases, surgical repairs for a corneal laceration or a broken bone.
Level 3:	**Medically Acceptable but not Medically Necessary**: provision of services to prisoners will be decided on a case-by-case basis. Examples: treatment of noncancerous skin lesions or routine nonincarcerated hernial repair.
Level 4:	**Limited Medical Value**: care will usually not be provided to prisoners. Examples: elective procedures such as tattoo removal or cosmetic surgery, minor conditions such as a common cold.

Source: **Compiled by the Legislative Audit Division from Department of Corrections' Policy Manual.**

Chapter III - Cost of Inmate Health Care in Montana

Introduction

This chapter presents information detailing the cost of providing health care to Montana Department of Corrections' inmates based on our review of the Statewide Budgeting and Accounting System (SBAS) and input from department personnel. Health care expenditure data is presented for fiscal years 1996 through 1999. It also contains a discussion of the factors which contribute to rising health costs.

Audit findings discussed in this chapter include the following:

- Each DOC inmate housed in a state-operated secure correctional facility incurred an average annual cost of $4,072 for adult males, $11,044 for adult females, $11,881 for juvenile males, and $16,895 for juvenile females for having basic medical care provided in fiscal year 1999. The weighted average annual medical cost of these groups is $4,967.

- DOC per-inmate health care costs are higher than most other western states we surveyed. Several of these states are also operating under court-ordered settlement agreements. This data is presented in Figure 2.

- DOC's per-inmate cost for medical services has risen significantly faster than the regional consumer price index for medical care. While the medical cost per inmate increased by 20 percent between fiscal years 1998 and 1999, the regional consumer price index for medical care rose by only 3.9 percent over the same period.

- The 1997 Legislature approved increases of over $3.6 million and 19.5 FTE over the 1999 biennium for increased medical costs and to implement legally adequate standards of health care. This was a 50 percent increase over fiscal year 1996 expenditures. The 1999 Legislature approved a General Fund increase of $1.6 million for medical services, which represents a 29 percent increase over fiscal year 1998 expenditures.

- DOC correctional system health care costs are not sufficiently controlled.

The Cost of Providing Health Care to Inmates

The following table details expenditures for medical services incurred in fiscal years 1996, 1997, 1998, and 1999.

Table 2
Inmate Health Care Expenditures
Fiscal Years 1996 through 1999

Category	FY 1996	FY 1997	FY 1998	FY 1999
Personal Services	$2,360,500	$2,071,198	$1,986,709	$2,604,056
Operating Expenses	4,429,190	4,434,871	5,240,877	5,625,934
Equipment Expenses	1,764	0	(1,507)	0
Benefits and Claims	332,571	0	0	0
Total	$7,124,025	$6,506,069	$7,226,079	$8,229,990

Footnote:
Medical expenditures do not include expenses for DOC central administration (director, legal, central service functions) or for operation of medical clinic and infirmary physical plants at DOC correctional facilities. Indirect medical expenses paid through room and board fees to contract bed providers are also not included in the table.

Source: Compiled by the Legislative Audit Division from SBAS records.

Medical costs in Table 2 represent the major part of health care service expenditures. Due to the department's use of county jails, regional prisons, and private prison facilities, some medical costs are paid as part of room and board. Subsequently, DOC is not able to identify indirect medical costs paid through daily room and board fees. More of the health care costs were shifted to room and board fees in fiscal years 1997, 1998, and 1999 as the department began using private and county-operated correctional facilities to house state inmates. For inmates in contracted correctional facilities, medical costs included in our analysis reflect only those medical costs paid for over and above room and board. Consequently, medical costs in our analysis represent a minimum cost of providing health services. In fiscal year 1999, the department spent at least

$8.2 million for inmate health services. This represented ten percent of every dollar appropriated to the Department of Corrections. Medical care paid for indirectly through room and board fees could amount to an additional annual expense of approximately $1.4 million in each of fiscal years 1997, 1998, and 1999. This is a conservative estimate which is based on the assumption that contracted correctional facilities adult medical costs per day are one-half of the DOC's adult medical costs per day. Table 3 presents this data.

Table 3
Inmate Health Care Expenditures Including Estimated Indirect Medical Costs
Fiscal Years 1996 through 1999

Category	FY 1996	FY 1997	FY 1998	FY 1999
Personal Services	$2,360,500	$2,071,198	$1,986,709	$2,604,056
Operating Expenses	4,429,190	4,434,871	5,240,877	5,625,934
Equipment Expenses	1,764	0	(1,507)	0
Benefits and Claims	332,571	0	0	0
Indirect Medical [1]	0	1,400,000	1,400,000	1,400,000
Total [2]	$7,124,025	$7,906,069	$8,626,079	$9,629,990

Footnote:
(1) Estimated indirect medical expenses paid through room and board fees for contracted beds.
(2) Medical expenditures do not include expenses for DOC central administration or for operation of medical clinic and infirmary physical plants at DOC correctional facilities

Source: Compiled by the Legislative Audit Division from SBAS and other states' information.

Table 4 details department expenditures for inmate medical services at each facility housing Montana inmates. Also included are medical expenses incurred by the department for inmates in prerelease centers. Expenditures are listed for fiscal years 1996 through 1999 and include total expenditures, as well as annual and daily costs per inmate for each facility. Cost per inmate was calculated using average daily population (ADP). Fiscal year-end populations were used for our cost per inmate calculations for the private prisons in Texas and New Mexico and the Cascade Regional Prison.

Table 4
Adult Health Care Expenditures by Facility
Fiscal Years 1996-1999

Facility	FY 1996	FY 1997	FY 1998	FY 1999	Contract Bed Housing Dates
Montana State Prison					
Facility Total	$ 4,966,364	$ 4,287,830	$ 4,737,412	$ 5,288,349	
Cost per Inmate - Annual	$ 3,578	$ 3,197	$ 3,603	$ 4,106	
Cost per Inmate - Daily	$ **9.80**	$ **8.76**	$ **9.87**	$ **11.25**	
Treasure State Correctional Training Facility					
Facility Total	$ 26,217	$ 13,895	$ 44,102	$ 82,428	
Cost per Inmate - Annual	$ 1,092	$ 496	$ 2,205	$ 2,659	
Cost per Inmate - Daily	$ **2.99**	$ **1.36**	$ **6.04**	$ **7.28**	
Montana Women's Prison					
Facility Total	$ 521,502	$ 549,479	$ 579,847	$ 762,057	
Cost per Inmate - Annual	$ 8,148	$ 7,963	$ 8,167	$ 11,044	
Cost per Inmate - Daily	$ **22.32**	$ **21.82**	$ **22.37**	$ **30.26**	
Private Prison - Texas (1)					
Facility Total		$ 314,970	$ 334,332	$ 3,810	July 1996-Dec. 1997
Cost per Inmate - Annual		$ 1,406	$ 2,675	N/A	
Cost per Inmate - Daily		$ **3.85**	$ **16.41**	N/A	
Private Prison - Tennessee (1)					
Facility Total			$ 252	$ 148,803	Sept. 1997- to date
Cost per Inmate - Annual			$ 2	683	
Cost per Inmate - Daily			$ **.01**	**1.87**	
Private Prison - Arizona (1)					
Facility Total			$ 728	$ 7,291	Oct. 1997 - to date
Cost per Inmate - Annual			$ 10	59	
Cost per Inmate - Daily			$ **.04**	**.16**	
Private Prison - New Mexico (1)					
Facility Total			$ 4,377	$ 10,215	May 1998 - to date
Cost per Inmate - Annual			$ 151	256	
Cost per Inmate - Daily			$ **2.47**	**.70**	
Regional Prison - Cascade (1)					
Facility Total			$ 14,261	$ 102,361	Jan. 1998 - to date
Cost per Inmate - Annual			$ 96	711	
Cost per Inmate - Daily			$ **.53**	**1.95**	
Regional Prison - Dawson (1)					
Facility Total				$ 90,923	Oct. 1998 to date
Cost per Inmate - Annual				1,581	
Cost per Inmate - Daily				**5.75**	
County Jail Holding (1)					
Facility Total	$ 76,018	$ 102,764	$ 459,243	$ 109,615	
Cost per Inmate - Annual	$ 563	$ 699	$ 2,404	1,014	
Cost per Inmate - Daily	$ **1.54**	$ **1.92**	$ **6.59**	**2.78**	
Pre-release Centers (2)					
Facility Total	$ 38,093	$ 78,046	$ 192,571	$ 341,347	
Cost per Inmate - Annual	$ 132	$ 249	$ 507	$ 767	
Cost per Inmate - Daily	$ **.36**	$ **.68**	$ **1.39**	$ **2.10**	

Footnotes:
(1) Represents only direct expenses for health care costs. Does not include indirect health care costs paid through room & board fees.
(2) Inmates in pre-release centers are responsible for first $200 of medical expenses.

Source: Compiled by the Legislative Audit Division from SBAS records and Department of Corrections population statistics.

We did not report medical cost per day for juvenile inmates on a facility basis. The manner in which the department records these expenditures limited our ability to fully ascertain juvenile health care costs.

Facilities Experiencing Fastest Growth in Health Care Expenditures

Between fiscal years 1996 and 1999, department expenditures for health care-related personal services and operating expenditures increased. In reviewing department expenditures for health care, large increases in expenditures include the following:

- The fiscal year 1999 medical cost per inmate at MSP rose by 14 percent over the prior year. At $5.2 million, MSP accounts for 64.3 percent of the approximately $8.2 million of fiscal year 1999 medical expenditures. MSP incurs the highest cost per day of the adult male secure facilities.

- The highest medical costs per inmate are incurred in caring for female inmates. Montana Women's Prison medical cost per inmate was $11,044 in fiscal year 1999, which compares to fiscal year 1996 cost of $8,148 per inmate. This represents a 36 percent increase.

- The medical costs associated with housing DOC inmates in county jail facilities increased by 244 percent in fiscal year 1998 to $2,404 per inmate.

Cost Comparisons Among Facilities Are Difficult

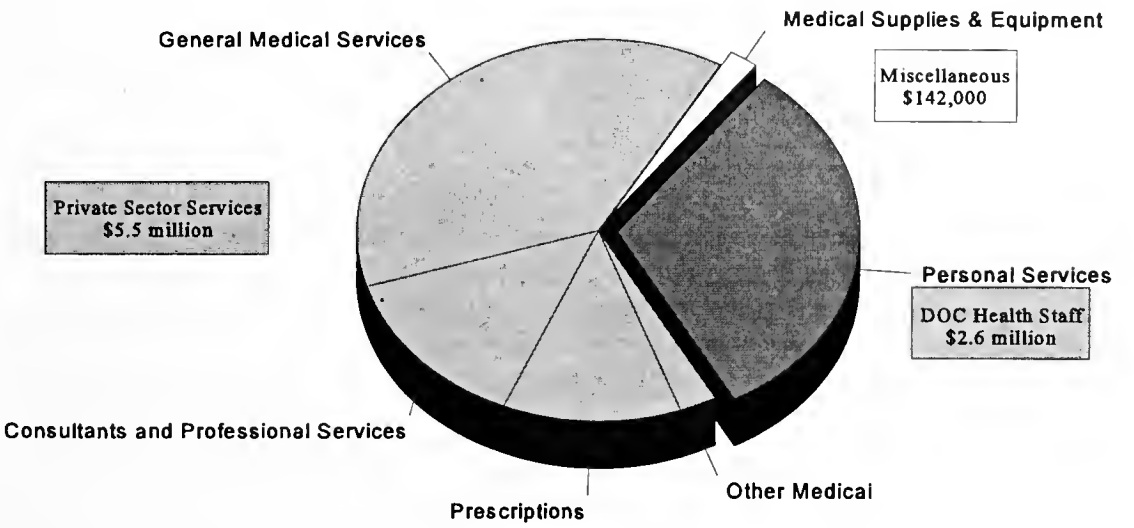
As discussed on page 18, some health care costs have been shifted from a direct cost to an indirect cost paid for through room and board fees. This shift occurred as the department began using private and county-operated prison facilities to house state inmates. Therefore, it is difficult to directly compare medical costs among contracted bed facilities and contracted bed facilities against state operated facilities.

Primary Health Care Expenditure Areas

We also examined the types of medical service expenditures incurred by the department. The following figure illustrates those areas where the majority of dollars are spent providing health care to inmates.

Figure 1

Primary Health Care Expenditure Areas
Fiscal Year 1999



Source: **Compiled by the Legislative Audit Division from SBAS records.**

In fiscal year 1999, the majority of expenditures for health services were for the private sector services. This includes both contracted and noncontracted providers who treat inmates either on site at the correctional facilities or off site at private clinics and hospitals. Expenditures for private sector services totaled $5.5 million in fiscal year 1999. Department personnel provided part of the medical services afforded inmates at Montana State Prison, Pine Hills Juvenile Correctional Facility, Treasure State Correctional Training Center, and Riverside Juvenile Facility. The department expended $2.6 million in personal services for department health services staff. Expenditures for medical supplies and equipment accounted for the remaining $142,000 of fiscal year 1999 expenditures.

In examining department expenditures for the various types of medical services which were provided to inmates, we noted the following:

- Between fiscal years 1998 and 1999, department personal services expenditures increased 31 percent.

- Expenditures for drugs and prescriptions increased 48 percent between fiscal years 1997 and 1998. The department spent over $1 million on drugs and prescriptions which accounts for 14.7 percent of fiscal year 1998 total medical expenditures. Fiscal year 1999 prescription costs decreased over the prior year.

- Between fiscal years 1997 and 1998, noncontracted medical services spending rose by 16 percent. This covers services provided by physicians, physical therapists, optometrists, dentists, and hospitals; clinical services such as laboratory, radiology and pathology; and ambulance services. This trend continued in fiscal year 1999 with a 15.7 percent expenditure increase.

- The department also increased its spending for contracted medical consultants and professional services by 37 percent between fiscal years 1996 and 1999. These are services provided by contracted health care providers. Fiscal year 1999 expenditures were close to $1.2 million.

- Department expenditures for laboratory testing rose by 72 percent between fiscal years 1998 and 1999.

Montana's Cost of Inmate Health Care Among the Highest of Western States

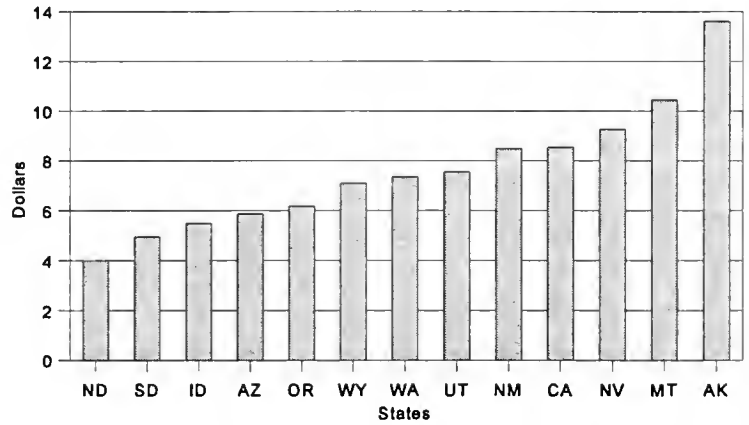
The cost of providing health care to Montana inmates appears higher than most other western states. In an effort to make an "apples to apples" cost comparison, we used expenditure data reported in The Corrections Yearbook, 1998 (the 1999 edition was not yet available). Other states report medical cost per inmate by combining adult male and female medical expenditures for inmates housed in state-operated secure facilities. DOC experienced an increase in total correctional health care spending of over 11 percent in fiscal year 1998. This compares with other states which report an average increase in total correctional health care spending of 5.8 percent.

The cost of providing medical services to adult inmates housed in Montana's state-operated facilities experienced an even higher increase of 13.3 percent between fiscal years 1997 and 1998. The department spent an average of $3,813 per inmate for adult inmates housed in state-operated facilities during fiscal year 1998. This compares with other states which report spending an annual average of $2,544 per adult inmate for health care.

Figure 2 compares Montana's daily health care expenditure per adult inmate to data provided by other western states. At a daily rate of $10.45 per inmate for fiscal year 1998, Montana's expenditures appear to be among the highest of the western region.

Figure 2

Montana Health Care Expenditures
Daily Medical Cost Per Adult Inmate
Fiscal Year 1998



Source: Montana medical cost per inmate compiled by the Legislative Audit Division from SBAS records. Other western states medical cost per inmate compiled from The Corrections Yearbook, 1998, Criminal Justice Institute.

According to the U.S. Department of Justice, several of these western states are also operating under court-ordered settlement agreements for provision of health care which impacts inmate health care expenditures in a manner similar to Montana.

Montana's Cost of Inmate Health Care Rising Faster Than Consumer Price Index

Department expenditures for inmate health services have grown at a significantly faster rate than overall consumer spending for health care services. While the medical cost per inmate increased by 20 percent, the regional consumer price index for medical care rose by 3.9 percent between fiscal years 1998 and 1999. In fact, annual growth in both the national and regional health care expenditures has remained below 5 percent since 1994. Department per capita

health care costs have risen significantly faster than the rate of inflation for health care.

Factors Which Increase Cost of Correctional Health Care

In the past five years there have been rapid and dramatic changes for the Montana Department of Corrections. The department has faced a number of major issues which may have been factors in the rising costs of health care for inmates. Foremost is the state's need for more inmate bed space. In response to this growth, the department turned to alternative means of housing inmates, including county jails, county-operated regional prisons, and privately operated prisons. Montana's adult correctional system evolved from three in-state secure facilities, all operated by the department, to a complex system of Montana inmates spread among nine secure facilities located both in-state and out-of-state. Management of the correctional system is now shared by state and county officials and privately operated facilities. The department no longer has direct operational control of all facilities. This system expansion has made it more complex to manage and control health care expenditures. There are now more facilities providing medical services to inmates and thus more facilities to oversee. In addition, the decentralization means systems to provide care must be duplicated and set up at each institution and thus opportunity for realizing efficiencies gained through economies of scale is limited. In addition to an increasing number of inmates and development of a decentralized prison system, the lawsuits filed over inadequate health care services at MSP were another key factor impacting medical expenditures.

According to the U.S. Department of Justice and other correctional health care experts, there are other factors which tend to influence the cost of providing medical care in a correctional setting:

- inmates seek medical services more often;
- minimal efforts to control inmate use of services;
- medical inflation;
- aging prisoner populations;
- dependence on external service providers;

- more female and juvenile prisoners;
- weak leverage over external service providers;
- increase in infectious diseases;
- limited efforts to negotiate better prices from private sector providers;
- increasing population of inmates with mental illnesses;
- litigation and litigious prisoners;
- catastrophic health episodes;
- unhealthy and chronically ill inmates; and
- costly medical advances in treatment and medications.

These issues are true of all states' correctional facilities, not just Montana's.

Other States Control Health Care Costs

Although there are many factors which can exert upward pressure on health care costs, other states report success in containing and reducing inmate medical costs. In a 1998 study of state correctional jurisdictions reported in the Corrections Compendium, among the 13 states that report either constant or decreased medical costs, implementing comprehensive managed care contracts and negotiating better discounts with private health care providers were key means of reducing costs.

Rising health care costs faced by the Montana Department of Corrections, the positive experiences of other states and the U.S. Department of Justice in operating federal prisons, and the testimony of correctional medical experts all suggest the need for increased monitoring and oversight of correctional health care by the DOC. Increased monitoring and oversight may enable the department to better control costs while ensuring an adequate system of health care delivery. The next chapter discusses management controls and strategies which we believe can help DOC increase oversight of correctional health care and enhance efforts to contain these costs.

Conclusion: Health Care Costs Not Sufficiently Controlled

As the prison system grows, the cost of providing health care to inmates is going to increase. If health care expenditures continue to grow as they have been, the department will spend at least $10 million on providing medical care to existing inmates in fiscal year 2001. This figure assumes no growth in the inmate population. Add an increasing population to this scenario and costs of health care will rise even further.

In reviewing the department's expenditures for inmate health care, we examined department expenditures for overall cost trends, compared Montana's correctional health care costs to other western states, and contrasted inmate health care expenditures to the rate of medical inflation for this area of the county. This review showed:

- Department expenditures for inmate health care have been consistently rising over time. Total dollars expended for correctional health care services increased 15.5 percent between fiscal years 1996 and 1999. During the most recent fiscal year, the average annual cost of providing health care to adult and juvenile inmates housed in state operated correctional facilities rose by 20 percent.

- Montana's cost of inmate health care appears to be among the highest of western states exceeded only by Alaska. Both the per capita costs and growth in total expenditures exceed most other western states.

- While the medical cost per inmate (state operated correctional facilities) in Montana rose by 20 percent between fiscal years 1998 and 1999, the rate of inflation for health care in this region of the country was 3.9 percent for the same period of time. The increases in the per capita medical costs for DOC inmates have consistently been greater than the Consumer Price Index (CPI) over the past four years.

Based on our review of health care expenditures, other states information, as well as our audit work regarding department monitoring of health care services, we conclude Montana's cost of providing inmate health care services are not sufficiently controlled.

Chapter IV - Improving Health Care Program Operations

Introduction

Typically, each individual audit finding and subsequent recommendation is directed at addressing the cause of a particular condition in our reports. In this chapter, we have nine recommendations to improve DOC health care program operations. However, there is an overriding "cause" for each of these recommendations. We believe the cause of all the noted conditions is a common denominator in each of the findings. Therefore, we first discuss the cause which each of our audit recommendations has in common and our recommendation to address the overall deficiency. We will then discuss additional recommendations directed at improving health care program operations.

DOC Focus Is Custody and Housing

Based on interviews with various DOC personnel, a significant portion of the department's attention in the past few years has been focused on establishing and maintaining public safety via obtaining bed space to alleviate overcrowding and increasing the number of security-related personnel. Until recently, the DOC has not placed as much emphasis or priority on administering and monitoring inmate medical care as necessary to fully satisfy federal district court expectations.

The primary reason for the lack of emphasis appears to be that for many years the DOC did not have any lawsuits or circumstances whereby inmates or others successfully challenged the provision of medical care at its facilities. However, even after signing the first court-ordered settlement agreement in 1994, the department did not appear to formally initiate a systematic approach to achieving compliance with the terms of the settlements until the fall of 1997. Additionally, review of historical budget-related documents suggest that until recently (1997 biennium), the department has not sought a substantial increase in funding for medical services personnel, even though there has been high turnover in personnel and an ever-increasing inmate population.

Department Medical Program Accomplishments

Since mid-1996, the department has undertaken preliminary steps towards establishing and managing a systemwide medical program. The following highlights positive steps taken by the department to manage systemwide medical program operations. The department:

- Created a central Health Services Management Bureau.
- Hired a full-time medical director.
- Contracted with Blue Cross/Blue Shield of Montana to process medical claims and to have access to a network of health care providers.
- Entered into an interdepartmental pharmacy contract.
- Sought legislative changes to gain authority to initiate inmate copayment for health services, redefine medical parole eligibility requirements, and implement an alternative method of dealing with inmate complaints against medical practitioners.
- Adopted policies regarding provision of health care.
- Developed a conceptual framework to define services which will and will not be provided.
- Instituted a Medical Review Panel to review medical necessity of elective or surgical procedures.
- Renovated the infirmary at MSP.

Increase Emphasis on Systemwide Management of Health Care

While the actions of the department address growing inmate medical issues, we believe they are only the first steps the department should implement. Department management still has not fully committed itself to emphasizing inmate health care administration. For example, while department management created a central Health Services Management Bureau, the bureau has been limited in its ability to function as it was intended: to provide systemwide management. The continual expansion and changing of facilities at which state inmates are placed has forced Health Services Management personnel to direct its primary efforts towards assisting facility management with establishing inmate medical delivery

systems at each of the nine facilities used to house adult and juvenile inmates. Gaining compliance with the federal district court settlement agreements governing the provision of medical services at MSP is the other key area towards which the personnel of the Health Services Management Bureau's time is dedicated. These two factors have had a considerable impact on the amount of time the Health Services Management Bureau has been able to devote to systemwide management.

The department hired a full-time medical director; however, he has little time available to focus on systemwide management of health care. Due to medical staffing shortages at MSP, the medical director provides primary-level care to inmates at MSP an average of three days per week. This severely limits the director's ability to focus on the other ten facilities providing care to Montana inmates. In another example, one key provision in the agreement with the U.S. Department of Justice requires the department to establish and maintain an adequate medical records system. Department management elected to automate the medical records system; however, no resources from the department's information services function were allocated to assist with automating medical records. As a result, the medical director assumed primary responsibility for designing, programming, and testing the medical records system.

We believe it is critical the department increase emphasis on systemwide management of inmate health care in order to avoid future litigation and control rapidly rising health care costs. As discussed in Chapter II, the costs associated with litigation can be substantial. The lack of department management emphasis on systemwide health care can also hamper staff's ability to provide adequate and timely medical care to inmates. Discussions with some contracted health care providers revealed frustration and concerns with the lack of department oversight. Several providers voiced concerns that the department is at further legal risk due to perceived inadequacies in health care services. They cited examples of errors in the distribution of medications; backlogs of inmates requiring medical intake screenings, dental services, and vision services; chronically ill inmates not receiving the level of care

needed to manage their diseases; and physicians not conducting on-site clinics at the minimum level specified by contract. The court-appointed monitors (who are correctional health care experts) also have voiced concerns with the level of care of some services provided at MSP, including the care of chronically ill inmates and the lack of continuity of care. The department's internal auditor has also identified concerns with health care services which are also consistent with a lack of management emphasis and systemwide oversight. Examples of concerns include inadequate inmate health care records, significant amounts of referrals to specialists, costly prescribing practices, and contractors being reimbursed at rates other than those specified in contracts.

Department management has an obligation to manage all activities related to the care and custody of adult and juvenile offenders remanded to the DOC. According to section 53-1-201, MCA, "The Department of Corrections shall use at maximum efficiency the resources of state government in a coordinated effort to:

(1) develop and maintain ***comprehensive services*** and programs in the field of adult and youth corrections; and

(2) provide for the custody, assessment, ***care***, supervision, ***treatment***, education, rehabilitation and work and skill development of youth ...". *(Emphasis added.)*

Since medical delivery systems are for the most part set up at each of the nine adult and juvenile correctional facilities and the department has gained compliance with a portion of the court-ordered settlements governing health services at MSP, department management should now emphasize systemwide oversight of the health care system.

Recommendation #1
We recommend the department increase emphasis on systemwide management of the inmate health care system.

The remainder of this chapter presents audit recommendations to emphasize systemwide management of health care. We have identified recommendations the department should implement to improve its operations and control over health care services and related costs. These recommendations include:

1. Expand long-range planning efforts.
2. Develop, compile, and analyze comprehensive management information.
3. Expand managed care strategies.
4. Strengthen and expand procedures for reviewing medical billing.
5. Create a systemwide process to evaluate quality of medical services.
6. Develop a contract administration and monitoring process.
7. Clarify lines of authority over unit health personnel.
8. Establish procedures to ensure proper transfer of medical information.

Expand Long-Range Planning Efforts

The National Commission on Correctional Health Care (NCCHC) has published guidelines for the management of an adequate health care delivery system. NCCHC stresses the importance of long-range planning for correctional health systems. Other governmental agencies rely on strategic planning. For example, federal agencies are required to prepare a five-year strategic plan with goals and objectives, and annual plans that measure progress towards achieving these goals. The annual plans are tied to the budget and lay out exactly how expenditures relate to the established priorities for the year.

The department now performs only limited strategic, long-range planning for the provision of health care services. Some long-range planning is performed during the department's executive planning process. However, planning is geared towards new proposals. It

lacks detail and does not target existing operations. For example, one proposal for the 2000-2001 biennium is to "renew the Montana Women's Prison" through a building project to increase capacity to 205 female offenders. However, the department does not have a detailed plan for providing health care to a population which will triple in size with the expansion. Specific plans outlining how desired outcomes will be accomplished have not been formulated.

As a result of the increasing inmate populations and the addition of more facilities to house inmates, the department and Health Services Management Bureau have operated in a reactionary mode with the focus being on the short term. In addition, the majority of the management efforts undertaken by the Health Services Management Bureau have been directed towards MSP health care operations.

The lack of long-range planning has contributed to the limited overall department emphasis on systemwide inmate health care issues and operations. It has also restricted the ability of the department's medical/mental health director to focus on systemwide health care issues. The director's time and efforts are primarily dedicated to gaining compliance with court settlement agreements and providing primary level psychiatric care to MSP inmates.

Detailed long-range planning would allow the department to:

- identify critical challenges facing inmate medical services;
- develop action plans for addressing those challenges;
- assign responsibility for carrying out identified tasks; and
- assess progress towards achieving goals.

The medical management team could benefit from this process because it is essential for changing operational focus from short-term to long-term and from being reactive to adopting a proactive approach. Detailed planning is needed to help focus the efforts of managing and operating a systemwide health care system which has nine facilities under its umbrella of control. Now that the basic

system of health care delivery is established in the facilities housing Montana inmates, department management should expand its long-range planning process.

Recommendation #2

We recommend the department expand its long-range planning process to include specific goals and measurable objectives for the entire correctional health care system.

Improve Data Compilation for Effective Health Care Delivery and Cost Containment

According to the U.S. Department of Justice, if correctional health care administrators are to manage health services successfully, they need to monitor many different aspects of this dynamic system. Without good information systems, effective management of cost and care is nearly impossible.

Currently, only limited information is compiled to help the department effectively manage inmate medical services and contain costs. The Health Services Management Bureau does receive management information from the medical claims administrator - Blue Cross/Blue Shield of Montana. While this information contains utilization and cost information, it covers only $2.5 million of the $8.2 million expended by the department for fiscal year 1999 health services. Thus, no cost data has been compiled for the majority of health services. Data provided by Blue Cross/Blue Shield relates to off-site medical service claims processed by the claims administrator. The department compiles only limited utilization and cost information for on-site services, contracted services, or services for which the department pays directly. While data is compiled for services at some facilities, other facility data is not available.

As a result of the lack of comprehensive management information, department management and the Health Services Management Bureau are uncertain as to total dollars expended in providing medical services. The current department focus is on paying bills; it has not taken the next step of comprehensively compiling and analyzing expenditure data. Department management was not able

to provide information as to how often inmates seek medical services at facilities such as the Montana Women's Prison or Riverside Juvenile Facility. In addition, there is no analysis of the utilization data which is compiled for MSP.

Incomplete management information limits the department's ability to effectively and efficiently manage the health services program. Without this data, the department cannot adequately monitor cost of services and goods or assess the demand for services, use of services, and the balance between demand and available resources. The lack of data limits the department's ability to negotiate discounts with medical providers. It also makes it difficult to monitor and evaluate providers' practices so as to make decisions about whether to give them more work or less work or to request they modify how they deliver services. Lack of data limits management's ability to assess adequacy of the patient-level delivery of services, including the quality of those services. The lack of comprehensive, systemwide health care information also restricts long-range planning ability. Without this data, it is difficult to assess feasibility, desirability, and cost effectiveness of alternative means of service provision, and to plan and budget for future services.

Health Care Use Data Needed

By developing a management information system, the following are examples of areas where information could be compiled to help the department determine effectiveness and efficiency of its medical program:

- Inmate use of on-site clinical services, such as number of health-related requests, number of clinic and infirmary visits, length of stay in infirmary, number of inmates seen by on-site physicians, number of missed appointments or refusals of treatment, and data on repeat visits to clinics.

- Inmate use of off-site medical services, such as number of outside appointments, types of appointments, numbers of appointment cancellations and reasons for cancellation, and number of inmate refusals for medical care.

- Comprehensive data related to medical condition of inmates, such as number of chronically ill inmates, number of inmates prescribed medications, or number of inmates with dental-related deficiencies.

- Data related to physician's practice patterns, such as number of referrals to off-site providers, prescription type and usage, and use of diagnostic services such as radiology.

Health Care Cost Data Needed

In addition, comprehensive cost reporting is also needed which captures medical cost information on a systemwide basis. Potentially costly and/or inefficient medical practices could then be identified and steps taken to correct or negate these usage trends. Data could also be used to improve quality and timeliness of medical services. Having access to this information would enable the department to better establish and evaluate its overall cost-containment strategies and utilization control techniques.

The department needs to develop, compile, and analyze comprehensive management information which captures data related to: (1) health care costs; (2) use of services; and (3) general health characteristics of inmates. In order to accomplish this, the department should identify information necessary to manage health care operations and measure performance. Staff from the Health Services Management Bureau should work together with the Administrative Services Division to identify and develop comprehensive health care cost reports. The department should also develop a process to capture information consistently from each facility regarding inmate utilization of both internal and external health services. Once cost and use information is compiled, the department should analyze the data to identify cost and usage patterns and use the results of the analysis to adjust the medical services inmates receive and for decisions regarding more cost effective provision of health care services.

Recommendation #3

We recommend the department develop, compile, and analyze comprehensive management information to allow for review of health care costs and utilization patterns systemwide.

Expand Managed Care Strategies

Managed care programs attempt to control cost of and access to health care services while ensuring quality of care. The U.S. Department of Justice and other correctional health care experts have found that many managed care techniques used in the community setting can also be effective in correctional settings. Numerous states have been able to achieve greater control of both costs and quality of inmate medical services as they adopt more managed care principles. Managed care techniques focus on two areas: (1) controlling cost of services, and (2) controlling prisoner's use of services.

While the department has implemented numerous managed care techniques, efforts could be expanded. The department needs to take additional steps to control cost and use of health care services. Areas where the department could achieve greater control include:

- Rates paid for some contracted and off-site health services appear to be high. For example, the department has not negotiated discounted rates with some of the primary medical providers. Several providers are currently reimbursed on a "usual and customary" fee basis. Some of these providers are hospitals where medical costs can accumulate quickly with hospitalizations, diagnostic testing, and specialty services. In addition, the department reimburses very few providers based on Medicaid or Medicare fee schedules. These schedules are key tools used by other states' correctional departments to reduce costs. Officials in these states negotiate reimbursement at Medicaid/Medicare fee schedules or at a percentage above Medicaid rates. Correctional health care experts recommend this approach rather than negotiating a discount from "usual and customary" fee schedules, which is the approach typically used by DOC.

- The department is performing only minimal retrospective (after the fact) reviews of services provided. No one reviews what prescriptions were provided to inmates to ensure cost-effective practices are followed. For example, each time a prescription is refilled, the department is charged a management fee. If refill periods were extended, management fees could be reduced. Retrospective reviews would also help ensure only drugs listed on the formulary (an approved list of drugs) are prescribed and generic drugs substituted for costly drugs. Reviews could also be used to identify other costly practices such as filling over-the-counter medications through physician prescriptions. Reviews should also examine individual physician and institutional prescribing practices. This procedure could be used to identify costly practices such as excessive amounts of outside referrals and use of diagnostic tests. This same issue applies to other aspects of health care and is discussed in next section of this chapter entitled "Strengthen and Expand Procedures for Review of Health Care Billing."

- Audit evidence further suggests policies designed to control or limit use of external medical services have been circumvented. For example, we noted instances where contract bed providers provided off-site and costly medical services to Montana inmates without prior authorization by the department.

While the DOC has implemented several managed care techniques over the past five years, our analysis of the department's health care cost controls indicates the possibility of achieving greater cost savings. Key areas to target are use of external medical services and prescriptions. The majority of health service dollars are expended in these areas. Overall, health care expenditures for Montana inmates increased at a rate more than triple that of expenditures for health care for this region of the country as a whole. Audit evidence suggests costly practices occur in providing inmates with health care. For example, while the number of outpatient visits to one local area hospital remained constant, the average cost per visit rose by 64 percent over a one-year period. The number of inmates transported by ambulance at one correctional site more than doubled over a one-year period. Another facility appeared to have a high rate of off-site referrals for health services; inmates in that facility averaged over three off-site

visits per year. Audit evidence further suggests inefficient and costly practices occur in providing prescriptions and medications to inmates. Department expenditures for prescriptions increased 102 percent between fiscal years 1997 and 1998. Expenditures for prescriptions and drugs provided to DOC inmates housed in county jails increased by almost 500 percent over the same time period.

The department needs to continue to take additional steps to control cost and use of services. Through additional and more comprehensive monitoring, the department could potentially reduce the use of external services, discourage costly prescribing and diagnostic procedures, and ultimately gain additional control over rising health care expenditures. The expansion of managed care strategies coupled with comprehensive cost and utilization data (audit recommendation #3) and review of medical billings (audit recommendation #5) will allow the department to better contain the rising costs of inmate health care services.

Recommendation #4

We recommend the department continue to expand its managed care strategies by:

A. Increasing emphasis on obtaining discounted rates from health care providers who currently receive payment based on the full "usual and customary" fee schedules.

B. Shifting toward the use of Medicaid or Medicare fee reimbursement schedules as a basis for beginning contract negotiations with health care providers.

C. Changing practices and priorities based on retrospective reviews of appropriateness of medical treatment and prescribing practices.

D. Enforcing adherence to department policy regarding prior authorization of off-site health care services.

E. Closely monitoring the use of off-site and ancillary services.

Strengthen and Expand Procedures for Review of Health Care Billing

The Health Services Management Bureau of DOC only conducts a limited review of the medical bills they receive for inmate medical services. Our audit work revealed gaps in the review of medical bills submitted by outside providers. The following examples highlight the actual and potential effects of the limited review:

- DOC has no assurance that services billed were actually provided. At present, there is no comparison by DOC Central Office or adult facility staff of medical bills to medical records for either medical treatment or provision of medications. As a result, we noted department documentation showing where medical providers were paid for services not provided. The outcome of these claims is yet to be determined by the department.

- DOC policy requires physician referrals to off-site medical providers be preapproved by the department medical director or Medical Review Panel. The purpose of the policy is to control access to outside medical care as a means to ensure only medically necessary services are provided and to exercise control over costly procedures. At present, despite department policy, most medical bills are not checked to ensure preapproval was obtained. We identified instances when preapproval was absent and the department paid for unauthorized services. We also noted instances when verbal authorizations for referrals were granted, but neither the authorization nor any supporting information was documented by department personnel.

- Blue Cross/Blue Shield, the contracted claims administrator, uses inmate offender numbers to ensure inmates were in the custody of the DOC at the time medical services were provided. We found the department does not consistently provide complete, updated offender listings to the claims administrator in a timely manner. As a result, medical claims were paid for persons who were not the responsibility of DOC. For example, we noted instances where county jail inmate medical bills and those of parolees no longer under the direct supervision of DOC were incorrectly paid because the claims administrator did not have an updated offender listing.

- The claims administrator and pharmaceutical provider submit listings of proposed provider payments to DOC prior to the payments being made. The department does not conduct a

comprehensive systemwide review of these listings to determine their reasonableness. There were subsequent discoveries of erroneous payments and payments for costly services when less expensive alternatives existed. For example, a review of the bills submitted by the pharmaceutical provider showed a physician's practice of giving prescriptions for over-the-counter medications, such as aspirin. Since a management fee is charged by the provider for filling prescriptions, the department paid more than was necessary for these medications. We estimate the cost of this practice increased department medical expenditures by an additional $33,000 in fiscal year 1998.

- Suspicious billing practices of two DOC medical providers have been referred to the Attorney General's office for investigation.

Although not precisely a method for obtaining lower prices, controlling costs by reviewing bills more closely is an effective cost containment strategy. According to the U.S. Department of Justice, correctional systems have saved money by strengthening the review procedures for bills submitted by outside medical providers. As an example, the state of Washington Department of Corrections recently conducted a pilot program to review its inmate medical bills. Within a short period of time, enough billing errors were identified and corrected to pay for the additional scrutiny and expand the program from one FTE to seven FTE.

There are several factors which have contributed to the weakness in the department's process for reviewing medical bills. These include:

- Department reliance on the claims administrator. While the claims administrator has computerized edits to check some medical bills for reasonableness, the administrator is not responsible for bills they do not process or for checking bills for compliance with department policy. The claims administrator is also not responsible for ensuring that billed services were actually provided.

- Department staff are unsure of responsibilities. We found department staff are uncertain of who should review billings.

They commonly assume either other staff or the claims administrator reviews medical bills. Staff confusion is aggravated by the fact that some medical bills are paid by central office personnel while others are submitted to the claims administrator for processing.

- Medical expenses are not always a facility responsibility. Since many medical expenditures are paid through the central office budget rather than a facility's budget, there appears to be a lack of ownership, and therefore scrutiny, of inmate medical bills by facility personnel.

During fiscal year 1999, the department spent approximately $5.5 million for contracted services, off-site health care, and prescription services. The department needs to increase resources and implement additional controls to strengthen its review of medical bills. The following outlines steps the department should consider to improve the billing review process:

1) Designate or assign staff responsibility for reviewing medical bills on a statewide basis.

2) Adopt procedures which detail what is to be reviewed on medical and pharmaceutical bills as well as how they should be conducted and procedures for assuring the claims administrator and pharmaceutical provider are given comprehensive and timely inmate listings.

3) Create a standardized medical preauthorization form and ensure all staff use the form when considering off-site medical referrals.

Implementing these recommendations will result in a more structured and thorough billing review effort and provide additional assurance the department is not paying for unnecessary or unreasonable services.

Recommendation #5
We recommend the department strengthen and expand procedures for review of medical billing by:

A. Designating responsibility for performing the reviews.

B. Adopting specific procedures for performing billing reviews and assuring updated eligibility information is provided to claims administrators in a timely manner.

C. Adopting a standardized medical preauthorization form and ensuring staff use it and provide the needed information.

Create a Systemwide Process to Evaluate Quality of Health Care

A systemwide quality improvement process ensures inmate health care satisfies federal court mandates of providing a constitutional system of health care in a correctional setting. A comprehensive quality improvement program is considered so vital to correctional health care, the National Commission on Correctional Health Care (NCCHC) requires a comprehensive quality improvement program be in place for the health clinics at prison units desiring accreditation and strongly encourages such a program for nonaccredited facilities. Quality improvement monitoring generally focuses on high-risk, high-volume, or problem-prone aspects of health care provided to inmates. Monitoring inmate health service use, periodic chart reviews and other quality improvement activities are performed in order to review and assess health services.

Examples of typical quality improvement activities endorsed by the NCCHC include checking timeliness and completeness of initial inmate health screenings, appraising diagnostic laboratory testing, reviewing necessity of emergency room visits, and assessing chronic disease care and management. Additional benefits of a quality improvement program include increased staff performance and elimination of inefficiencies in the health care delivery system, all of which help to reduce costs.

The primary focus of the department's quality improvement efforts to date has been on health services provided to MSP inmates. While there has been some monitoring of health services provided to inmates at other correctional facilities, visits have been sporadic and not all facilities have received a quality review. For example, no health care quality review was done for the first 11 months a contracted bed facility was used to house DOC inmates. When department medical staff finally performed a review of medical services, significant deficiencies were identified, including no post-surgical followup and failure to implement critical physician's orders. Additionally, department staff have not performed a followup visit to determine whether problems noted at this facility have been corrected even though nine months elapsed since the initial review. Another example of deficiencies in current quality improvement practices is physician review of inmate charts have not been performed at all correctional facilities housing Montana inmates.

An incomplete systemwide quality improvement program potentially contributes to many of the deficiencies with health care services noted during our audit. DOC management acknowledges that a lack of systemwide quality improvement programs can negatively impact operations. A 1999 Biennium Executive Planning Process (EPP) Request prepared by the department states, "While quality health care for inmates is not an important consideration for the average taxpayer, avoiding pervasive interference with the operations of the State's correctional institutions must be a recognized priority because of the extraordinary costs imposed on taxpayers when such legal action is commenced."

The department needs to expand quality improvement efforts to the other correctional facilities housing Montana inmates. Discussions with Health Services Management Bureau staff indicate the majority of their quality improvement efforts have been directed at MSP in order to gain compliance with the court-ordered settlements. Performing reviews at other correctional facilities has not been a priority. Health Services Management Bureau staff have not developed a long-range schedule of quality review and improvement

visits to be performed. Staff fit in reviews as time allows. The Health Services Management Bureau is comprised of three staff, two of whom perform quality improvement reviews in addition to their other duties. Staff indicate other constraints on their time limit their ability to perform quality improvement review work.

We acknowledge that Health Services Management Bureau staff are responsible for overseeing a large and diverse health services program. However, the department received substantial funding and FTE increases to implement legally adequate standards of health care during the 1999 biennium. Additional funding for inmate health services was granted for the 2001 biennium. The department should consider how they are allocating these additional resources and determine if additional resources can be directed at fully implementing a systemwide quality improvement program. Several options that would enable DOC to expand the quality improvement program include:

- reallocating other department staff to the Health Services Management Bureau,
- enlisting the help of unit (facility) health services staff in performing some quality improvement functions, and/or
- contracting with the private sector to perform quality improvement reviews.

Provisions also need to be made to ensure problems identified during regularly scheduled quality improvement reviews are resolved and that timely followup visits are performed at facilities identified with medical system deficiencies.

Recommendation #6
We recommend the department:

A. Implement a systemwide quality improvement program.

B. Establish a formal schedule of facility visits by a quality improvement team.

C. Develop procedures to ensure problems identified during quality improvement reviews are resolved in a timely fashion.

Develop a Contract Administration and Monitoring Process

The DOC relies on contractors to provide many of the health services to Montana inmates located in state-operated facilities, county-operated regional prisons, and privately operated correctional facilities. In some facilities, contractors supplement services provided by department staff while contractors provide all health services for inmates at other facilities. In fiscal year 1999, the department spent over $1.2 million for contracted consultant and professional health-related services. At the time of the audit, the department had 30 contracts which were exclusively for health-related services. The department had another 60 contracts which contained provisions regarding health services in addition to other contractual duties. Examples of larger health service contracts include physician and dental services provided on-site at MSP; operation of the MWP's health care clinic; medical services for juveniles; pharmaceutical operations; and the third party medical claims administrator.

During the audit, concerns were identified with the administration and monitoring of health services contracts. Concerns with controls over the department's contracts were also identified during separate audits performed by the Legislative Audit Division Financial-Compliance report (98-16) and by DOC's internal auditor. Several concerns relate to the general administration of health service contracts. First, department management was not aware of all health-related contracts currently in effect. Although an inventory-

type listing of contracts was prepared, it was incomplete and contained inaccurate information. Secondly, department officials sometimes wait until contracts are almost ready to expire or have expired prior to beginning contract renegotiations. As a result, contractors continue working for the department without a valid contract. Third, we identified instances where contractors have been paid at rates higher than those stipulated in contracts. For example, the department's contract with one medical provider stipulates the provider will be reimbursed for services rendered based upon the Medicaid reimbursement schedule. The contractor was billing the department on a "usual and customary" basis, not the Medicaid rate basis stipulated in the contract. This oversight amounted to over $17,000 in additional costs above and beyond the contracted rate. The department and claims administrator each absorbed a portion of the overpayment. Other instances of improper contractor billing have been identified. In addition, negotiated contract rates are not always provided to the department's third party claims administrator which also resulted in consultants being overpaid. Overpayments to a contracted provider of laboratory services amounted to approximately $100,000.

We also found the department's process for monitoring contractor compliance with the terms of a contract has not been thoroughly defined or organized. During the audit, we identified instances of contractors not performing duties as stipulated in the contracts and instances where the quality and efforts of contractor performance are questionable. For example, we obtained evidence suggesting a contracted physician was not performing the minimum number of weekly prison visits stipulated in the contract. The correctional experts monitoring the department's efforts in gaining compliance with the terms of the court settlements also voiced significant concerns with the quality of services being provided by medical contractors working with MSP inmates.

Careful and ongoing monitoring of vendor practices, quality of care provided, and contract compliance are essential cost containment and management controls. A lack of clearly defined administrative responsibility contributes to the concerns identified with department

health care contracts. Based upon interviews with various DOC personnel, management and staff are uncertain as to which central office function should be administering and monitoring health service contracts: the Health Services Management Bureau or the Contract Administration Bureau within the Administrative Services Division. Similar confusion is also evident at each correctional facility. The roles of individual correctional unit staff and the newly created positions of on-site contract monitors are also unclear regarding responsibility for administering and monitoring the large number of health service contracts.

Recommendation #7

We recommend the department develop a contract administration and monitoring process which:

A. Clarifies responsibilities for contract administration and monitoring.

B. Includes a thorough inventory of all health service contracts.

C. Ensures contracts are signed in a timely manner.

D. Verifies the department reimburses providers at rates stipulated in contracts.

E. Ensures applicable rates are provided to the third-party claims administrator in a timely manner.

F. Designates specific staff to perform monitoring functions.

G. Includes monitoring procedures and a monitoring schedule.

Clarify Lines of Authority Over Unit Health Care Personnel

The National Commission on Correctional Health Care (NCCHC) has established guidelines for the management of correctional health service delivery systems. The guidelines state, "In order to ensure that statewide policies and procedures are implemented at the prison units and that professional standards of care are followed, the Health Services Director must have line authority over unit (correctional facility) health staff." The guidelines also address the system of "dual supervision" where facility health personnel are clinically and professionally responsible to the statewide medical director, but are responsible administratively to the head of the prison in which they work. NCCHC states that the drawbacks to the dual supervision system are that areas of authority are not well-defined and conflicts can develop between the wardens and the medical director.

Montana has a dual supervision system. Both management and staff are confused regarding line supervision of health professionals at each correctional facility. In some circumstances, line supervision of health professionals rests with the statewide medical director and in others, supervision rests with the wardens at the individual institutions. The issue is further complicated by the addition of contracted health services staff. It is unclear whether contracted health services staff report to the statewide medical director, the facility warden, or to the central office's Contract Administration Bureau. The managerial lines of authority and responsibility are inconsistent.

As a result of unclear lines of supervision, facility-based health services staff are uncertain who to seek guidance from related to health care issues. For example, we identified instances where health care providers were uncertain whether health-related episodes should be documented and who they should seek guidance from. The confusion regarding lines of authority also makes it difficult to achieve uniformity across the institutions' health care programs. For example, medical record documentation varies at each correctional facility. Another example is each correctional facility uses a different procedure for ordering prescriptions from the department's pharmaceutical provider.

NCCHC guidelines state the most important consideration at each correctional facility is to ensure health services are organized under a single health authority. NCCHC guidelines also recommend designating a unit health authority (Chief Health Officer) at each individual correctional facility. That way there is someone accountable for the operation and management of each individual correctional facility's health delivery system. The DOC recently designated a health authority at MSP by hiring a Director of Nursing who is responsible for managing the daily operations of the infirmary. However, unit authority for managing health services has not been clearly designated for the other correctional facilities.

The reporting structure of the entire health services delivery system needs clarification. The department should re-examine its current organizational structure for health services and decide who will have line authority over medical services staff within each institution and whether they wish to continue with a dual supervision system or designate a single authority. In addition, the department should designate a chief health officer at each institution as the facility point of contact and as the primary responsible party for that facility's health services operations. The roles and responsibilities of all managerial staff should be clearly defined and specifically stated with regard to inmate health care. Once these decisions are made, they need to be clearly communicated to staff so facility health care staff understand who they are responsible for reporting to.

Recommendation #8
We recommend the department:

A. Formally re-examine each facility's health care services organizational structure.

B. Designate a Chief Health Officer at each correctional facility.

C. Clearly define the roles and responsibilities of facility managerial staff regarding health services responsibilities.

Establish Procedures to Ensure Proper Transfer of Health Care Information

With the addition of more correctional facilities to the Montana correctional system, it has become more common for inmates to move between facilities during their incarceration. Movement of inmates presents challenges in providing medical care. When an inmate is moved to another facility, responsibility for medical care of that inmate is also transferred. Ensuring proper medical care of inmates continues during and after intra-system transfers is of utmost importance, especially for the chronically ill, for inmates with communicable diseases, or for inmates taking medications.

The National Commission on Correctional Health Care (NCCHC) recommends when inmates are transferred from one unit to another within the prison system, they be accompanied by their health records. Health information is needed so medical staff at the receiving facility know what the health treatment plan is for each inmate. The record must be reviewed within 12 hours of the inmate's arrival so there are no unreasonable delays in continuing the patient's medications, treatments, etc. NCCHC also recommends a health summary transfer form that includes the following items: any known allergies; date of last tuberculosis skin test or chest x-ray; identification of any medical, dental, or mental health problems; current medications; ongoing treatment; and any pending appointments for diagnostic work or specialty care. If health care staff do not take steps (including transfer of medical information) to ensure inmate health care is continued throughout the period of incarceration, health problems can be exacerbated. Improper health care also places the state at legal risk for lawsuits.

During our audit, we found the department is plagued with interruptions in medical treatment resulting from intra-system transfers. For example, when inmates were moved from MSP to the regional prisons, we identified instances where inmates were transferred without any medical records, health history, treatment plans, or prescribed medication listings. In one instance an inmate who was prescribed medication for the treatment of rheumatoid arthritis was transferred to a regional prison without any accompanying medical records or medication. The receiving institution had no knowledge of the inmate's medical condition nor

medication needs until the inmate submitted a request because he had not received his medication. This particular medication requires monitoring by a health care provider.

Facility health managers and staff also stated that when medical information is provided for transferred inmates, it often lacks detail. The problems with transferring medical records and prescription information occurs repeatedly. We found the examples were not isolated instances.

It appears the primary reason medical records are not transferred with inmates is staff are uncertain of procedures to be followed in preparing inmates for transfer. Numerous individuals are involved with setting up the transfers so responsibility for specific things such as ensuring a medical history or treatment plan is sent to the receiving institution is not clearly defined. The problem is further aggravated by the use of different forms used by the various correctional facilities. The department needs to develop medically-related procedures pertaining to transfer of inmates. Procedures should define or designate a person responsible for ensuring necessary medical information is transferred to the receiving institution. The department should also adopt a standardized intra-system medical transfer form or treatment plan.

Recommendation #9
We recommend the department:

A. Develop and communicate procedures to ensure proper transfer of medical information during intra-system transfers.

B. Designate a person responsible for ensuring medical record transfer at each facility.

C. Adopt a standardized intra-system medical transfer form or treatment plan.

Summary

Less than five years ago, the DOC operated all five of the secure care facilities where adult and juvenile offenders were housed. By the end of the fiscal year 2000, the DOC is projected to have 2,200 inmates in at least nine different facilities, not including the prerelease centers. Some of the facilities are state-operated, others are contracted. All of the DOC inmates are the responsibility of the state of Montana and all must receive and have access to health care services. The complexity and size of the inmate health care system has more than doubled as the result of inmate population growth and the changes made to administer this population.

Our audit report states the DOC has focused the majority of its attention and resources on assuring public safety via expanding the number of available prison beds and increasing personnel responsible for the security and supervision of those inmates. As a result of the department's focus, there has been less attention given to other department responsibilities, such as the provision of health care which meets existing case law and judicial standards.

While we recognize the DOC has begun to address some of the issues associated with the administration of inmate health care, the audit report shows there should be improvements made in that administration. The department's focus must shift to assuring the entire corrections system is operated in the most efficient and effective manner possible. Part of this assurance is meeting inmate health care requirements, yet operating a health care delivery system which is responsive to taxpayer concerns regarding government services.

Our report recommendations provide a framework to make the DOC's administration of inmate health care services more efficient and effective from both an operational and cost standpoint.

Agency Response

DEPARTMENT OF CORRECTIONS

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February 23, 2000

FEB 2 5 2000

RE: Response to Legislative Audit Recommendations

Mr. Scott A. Seacat
Legislative Auditor
Legislative Audit Division
Room 135, State Capitol
PO Box 201705
Helena MT 59620-1705

Dear Mr. Seacat:

Thank you for the opportunity to respond to the performance audit report of the Department of Corrections for Inmate Medical Services. We have reviewed the recommendations, and the department concurs with the findings of the audit report. Our responses to each recommendation follow:

RECOMMENDATION # 1:
WE RECOMMEND THE DEPARTMENT INCREASE EMPHASIS ON SYSTEMWIDE MANAGEMENT OF THE INMATE HEALTH CARE SYSTEM.

Response: We concur. The department's medical director is responsible for the department's health care system. The department will re-emphasize this with its management team. Part of the department's problems lie in the wording of some state statutes. The department will consider legislation to clarify statute and the fact that inmate health care is a centralized function within the department.

RECOMMENDATION # 2:
WE RECOMMEND THE DEPARTMENT EXPAND ITS LONG-RANGE PLANNING PROCESS TO INCLUDE SPECIFIC GOALS AND MEASURABLE OBJECTIVES FOR THE ENTIRE CORRECTIONAL HEALTH CARE SYSTEM.

Response: We concur. The department will expand its EPP process this year to include specific goals and measurable objectives for the Health Care System. The department is also taking the lead for a strategic planning session this fall for statewide corrections.

RECOMMENDATION # 3:
WE RECOMMEND THE DEPARTMENT DEVELOP, COMPILE, AND ANALYZE COMPREHENSIVE MANAGEMENT INFORMATION TO ALLOW FOR REVIEW OF HEALTH CARE COSTS AND UTILIZATION PATTERNS SYSTEMWIDE.

Response: We concur. The department has developed a database that will provide this information. The department is currently testing this application at the Montana State Prison and will expand it to all facilities as soon

as testing has been completed. The department's Health Services Bureau will then use the information this database creates to analyze costs and measure the success of cost containment measures the department has implemented.

RECOMMENDATION # 4:
WE RECOMMEND THE DEPARTMENT CONTINUE TO EXPAND ITS MANAGED CARE STRATEGIES BY:

A. INCREASING EMPHASIS ON OBTAINING DISCOUNTED RATES FROM HEALTH CARE PROVIDERS WHO CURRENTLY RECEIVE PAYMENT BASED ON THE FULL "USUAL AND CUSTOMARY' FEE SCHEDULES.
B. SHIFTING TOWARDS THE USE OF MEDICAID OR MEDICARE FEE REIMBURSEMENT SCHEDULES AS A BASIS FOR BEGINNING CONTRACT NEGOTIATIONS WITH HEALTH CARE PROVIDERS.
C. CHANGING PRACTICES AND PRIORITIES BASED ON RETROSPECTIVE REVIEWS OF APPROPRIATENESS OF MEDICAL TREATMENT AND PRESCRIBING PRACTICES.
D. ENFORCING ADHERENCE TO DEPARTMENT POLICY REGARDING PRIOR AUTHORIZATION OF OFF-SITE HEALTH CARE SERVICES.
E. CLOSELY MONITORING THE USE OF OFF-SITE AND ANCILLARY SERVICES.

Response: We concur. Once the medical database is operational the department will use the information to identify additional managed care strategies. The department has also increased its efforts on enforcing prior authorization of health care services. The department does not foresee the possibility of obtaining Medicaid or Medicare fee reimbursements given the difficulty obtaining medical professionals willing to work in the correctional field, but it will start using these rates at the beginning of contract negotiations.

RECOMMENDATION # 5:
WE RECOMMEND THE DEPARTMENT STRENGTHEN AND EXPAND PROCEDURES FOR REVIEW OF MEDICAL BILLING BY:

A. DESIGNATING RESPONSIBILITY FOR PERFORMING THE REVIEWS
B. ADOPTING SPECIFIC PROCEDURES FOR PERFORMING BILLING REVIEWS AND ASSURING UPDATED ELIGIBILITY INFORMATION IS PROVIDED TO CLAIMS ADMINISTRATORS IN A TIMELY MANNER.
C. ADOPTING A STANDARDIZED MEDICAL PREAUTHORIZATION FORM AND ENSURING STAFF USE IT AND PROVIDE THE NEEDED INFORMATION.

Response: We concur. The department has clarified responsibilities and will develop written procedures with regard to reviewing and approving medical bills. The department will also establish procedures to clarify the process and increase standardization of the pre-authorization form.

RECOMMENDATION # 6:
WE RECOMMEND THE DEPARTMENT:

A. IMPLEMENT A SYSTEMWIDE QUALITY IMPROVEMENT PROGRAM.
B. ESTABLISH A FORMAL SCHEDULE OF FACILITY VISITS BY A QUALITY IMPROVEMENT TEAM.
C. DEVELOP PROCEDURES TO ENSURE PROBLEMS IDENTIFIED DURING QUALITY IMPROVEMENT REVIEWS ARE RESOLVED IN A TIMELY FASHION.

Response: We concur. The department will expand its current quality improvement within existing resources. As part of the expansion of this program the department will establish a schedule that will ensure all facilities are visited each year. The department will also develop a formal process to identify corrective action plans and ensure these actions are completed as planned.

RECOMMENDATION # 7:

WE RECOMMEND THE DEPARTMENT DEVELOP A CONTRACT ADMINISTRATION AND MONITORING PROCESS WHICH:

A. CLARIFIES RESPONSIBLITIES FOR CONTRACT ADMINISTRATION AND MONITORING.
B. INLUDES A THOROUGH INVENTORY OF ALL HEALTH SERVICE CONTRACTS.
C. ENSURES CONTRACTS ARE SIGNED IN A TIMELY MANNER.
D. VERIFIES THE DEPARTMENT REIMBURSES PROVIDERS AT RATES STIPULATED IN CONTRACTS.
E. ENSURES APPLICABLE RATES ARE PROVIDED TO THE THIRD-PARTY CLAIMS ADMINISTRATOR.
F. DESIGNATES SPECIFIC STAFF TO PERFORM MONITORING FUNCTIONS.
G. INCLUDES MONITORING PROCEDURES AND A MONITORING SCHEDULE.

Response: We concur. The department's Contracts Bureau has developed a tracking system to track all contracts. This includes a listing of all Health Services contracts. The Contracts Bureau and Accounting Bureau are developing procedures to ensure contracts are signed prior to any payments being made on the contract. The department will clarify procedures and responsibilities related to monitoring contracts.

RECOMMENDATION # 8:

WE RECOMMEND THE DEPARTMENT:

A. FORMALLY RE-EXAMINE EACH FACILITY'S HEALTH CARE SERVICES ORGANIZATIONAL STRUCTURE.
B. DESIGNATE A CHIEF HEALTH OFFICER AT EACH CORRECTIONAL FACILITY.
C. CLEARLY DEFINE THE ROLES AND RESPONSIBLITIES OF FACILITY MANAGERIAL STAFF REGARDING HEALTH SERVICES RESPONSIBILITIES.

Response: We concur. The department will request technical assistance to review and make recommendations for staffing and organization of the Health Services Bureau. The department will also communicate to department personnel who the designated Health Officer is for each facility and clarify the roles of facility management staff regarding Health Services.

Thank you again for your time. We wish to thank your staff for their suggestions for improving the effectiveness of the Department of Corrections and for their courtesy in working with our staff.

Sincerely,

RICK DAY
Director

RD/set

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